COUNTY MEDICAL SERVICES PROGRAM SCREENING STATEMENT

Applicant's Name _____ Social Security Number _____

Residence Address _____ City _____ Zip _____

Phone _____ How did you learn about CMSP? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY:

1. Are you a legal U.S. citizen or a permanent resident of the U.S.?. . . . . YES [ ] NO [ ]
2. Are you now a resident of San Luis Obispo County?. . . . . YES [ ] NO [ ]

IF YOU ANSWERED "NO" TO #1 OR 2, PLEASE RETURN THIS FORM TO RECEPTION.

3. Are you under age 21 or are you age 65 or older?. . . . . YES [ ] NO [ ]
4. Are you pregnant?. . . . . YES [ ] NO [ ]
5. Do you have terminal cancer?. . . . . YES [ ] NO [ ]
6. Have you lost two or more limbs?. . . . . YES [ ] NO [ ]
7. Are you paraplegic or quadriplegic?. . . . . YES [ ] NO [ ]

IF YOU ANSWERED "YES" TO # 3,4,5,6, OR 7, YOU NEED TO APPLY TO MEDI-CAL.

8. Do any children (under the age of 21) live with you? . . . . . YES [ ] NO [ ]
9. What is your medical problem? _____
10. Have you received any medical care or had prescriptions filled . . . . . YES [ ] NO [ ]
    in the past 7 days? If yes, please give date: _____
11. When is your next doctor appointment or prescription refill? _____
12. Name of doctor, hospital or clinic: _____
13. What PRESCRIBED medications do you take? _____
14. Are you scheduled for surgery? . . . . . YES [ ] NO [ ] If yes, when? _____
15. Do you have a medical problem that keeps you from working at ANY type of job for 12 months or more?
    . . . . . YES [ ] NO [ ]
16. Do you have a current application pending, as a disabled person, for any of the following programs; or do you intend to apply for any of these programs? If you answer "yes", please fill in the date of your application.
    A. Medi-Cal . . . . . YES [ ] NO [ ] Date _____
    B. Supplemental Security Income (SSI) . . . . . YES [ ] NO [ ] Date _____
    C. Social Security Disability (SSD) . . . . . YES [ ] NO [ ] Date _____
17. Are you a veteran? . . . . . YES [ ] NO [ ]
18. Do you have health insurance? . . . . . YES [ ] NO [ ]
19. Within the last year, have you lost your health insurance due to becoming unemployed? . . . . YES [ ] NO [ ]
20. Are you currently employed, but have lost your health insurance because the insurance company has gone out of business or has discontinued coverage for this area? . . . . . YES [ ] NO [ ]
21. Are you currently employed but unable to afford health insurance due to premium increases? YES [ ] NO [ ]

For County Use Only _____

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_____ IN _____ OUT _____

You or your representative must come to the CMSP Eligibility office within 7 days of receiving medical care or prescription medication. The date you sign the CMSP Eligibility screening statement (or 7 days prior) can be used as your beginning CMSP eligibility date only if you or your representative return to the CMSP Eligibility office with your completed CMSP application for a face-to-face interview within 7 days of the date you sign this CMSP screening statement. This 7-day period includes weekends and holidays.

Signature of person completing form _____ Date _____ Screened by _____